RX.PA.036.CCH Tysabri® (Natalizumab)

The purpose of this policy is to define the prior authorization process for Tysabri® (natalizumab).

Tysabri® (natalizumab) is indicated as monotherapy for the treatment of members with relapsing forms of multiple sclerosis (MS) and for inducing and maintaining clinical response and remission in patients with moderately to severely active Crohn's disease (CD) with evidence of inflammation, who had an inadequate response to, or are unable to tolerate conventional CD therapies and Tumor Necrosis Factor (TNF) alpha inhibitors.

DEFINITIONS

Kurtzke Expanded Disability Status Scale (EDSS) – a method of quantifying disability in multiple sclerosis (MS). EDSS steps 1.0 to 4.5 refer to MS patients who are fully ambulatory; EDSS steps 5.0 to 9.5 are defined by the impairment in ambulation.

Tysabri Outreach Unified: Commitment to Health (TOUCH™) – TOUCH is a restricted distribution program focused on safety and developed with the help of the FDA. Only prescribers and patients enrolled in the TOUCH prescribing program can prescribe and receive Tysabri® (natalizumab) and only certain pharmacies and infusion sites authorized by the TOUCH prescribing program can dispense and infuse Tysabri® (natalizumab).

POLICY

It is the policy of the Health Plan to maintain a prior authorization process that promotes appropriate utilization of specific drugs with potential for misuse or limited indications. This process involves a review using Food and Drug Administration (FDA) criteria to make a determination of Medical Necessity and approval by the Medical Policy Committee.

The drug, Tysabri® (natalizumab), is subject to the prior authorization process.

PROCEDURE

Initial Authorization Criteria:

Must meet all the criteria listed under the respective diagnosis:

1. Multiple Sclerosis

- Must be prescribed by a neurologist who is registered with the TOUCH Prescribing program
- Must have a diagnosis of a relapsing form of MS
- Must be age 18 years or older
- Must have previously had an inadequate response or intolerance to at least 1 preferred multiple sclerosis therapy
    - Preferred MS therapies covered through the pharmacy benefit may be found via https://countycare.com/formulary-tool/
    - Previous trial of another multiple sclerosis therapy is not required in the following patients:
        - Patients with rapidly evolving, severe relapsing remitting MS, defined as 2 or more disabling relapses in 1 year AND with 1 or more Gadolinium enhancing lesions on brain MRI or a significant increase in T2 lesion load as compared to a previous recent MRI7 OR
        - Patients who have 3 or more predictive factors of poor prognosis:
            - Age of onset 40 years or older
            - Motor system involvement at onset including weakness of the extremities or ataxia
            - 4 or more T2-weighted lesions suggestive of MS seen on MRI
            - 2.5 years or less between the first 2 relapses
            - 2 or more relapses in the first year of disease
            - Poor recovery from the initial 2 relapses defined as an EDSS of 1.5 or higher sustained for at least 1 year
- Must currently not have or have a history of progressive multifocal leukoencephalopathy (PML)
- Must not be receiving chronic immunosuppressant or immunomodulatory therapy (including interferon beta-1a, interferon beta-1b, glatiramer acetate, or fingolimod) or have systemic medical conditions resulting in significant compromised immune system function

2. Crohn's Disease

- Must be prescribed by a gastroenterologist who is registered with the TOUCH Prescribing program
- Must have a diagnosis of moderately to severely active CD with inflammation
- Must be age 18 years or older
- Must have previously tried conventional therapies such as corticosteroids or at least 3 months of immunomodulators (i.e., azathioprine, 6-mercaptopurine) or had an inadequate response or intolerance, side effects/toxicity, or have a contraindication to these therapies

- Must have an adequate trial (of at least 3 months) and failure of at least 2 preferred tumor necrosis factor (TNF)-alpha inhibitor with an inadequate response, or significant side effects/toxicities, or have a contraindication to these therapies
    - Preferred self-injectable alternatives covered through the pharmacy benefit may be found via https://countycare.com/formulary-tool/
- Must not currently have or have a history of progressive multifocal leukoencephalopathy (PML)
- Must not be receiving chronic immunosuppressant or immunomodulatory therapy (including 6-mercaptopurine, azathioprine, cyclosporine, methotrexate, or inhibitors of TNF-alpha) or have systemic medical conditions resulting in significant compromised immune system function

Reauthorization Criteria:

All prior authorization renewals are reviewed to determine the Medical Necessity for continuation of therapy. Authorization may be extended based upon:

1. Multiple Sclerosis:

- Chart documentation from the provider that the member's condition has stabilized or improved based upon the prescriber's assessment while on therapy
- Documentation that there is no evidence of progressive multifocal leukoencephalopathy (PML)

2. Crohn's Disease:

- Started Tysabri® while NOT on chronic oral corticosteroids: chart documentation from the provider that the member's condition has stabilized or improved based upon the prescriber's assessment while on therapy
- Started Tysabri® while on chronic oral corticosteroids: the patient is tapered off oral corticosteroids within 6 months of starting Tysabri®
- For all Crohn's disease patients, must have documentation that there is no evidence of progressive multifocal leukoencephalopathy (PML)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to 1 year
Reauthorization	Same as initial
Quantity Level Limit	
Tysabri®	1 vial per 28 days

If the established criteria are not met, the request is referred to a Medical Director for review, if required for the plan and level of request.

HPCPS Code

Code	Brand	Description
J2323	Tysabri	INJECTION, NATALIZUMAB, 1 MG

REFERENCES

1. Tysabri [package insert]. Cambridge, MA: Biogen Idec Inc.; January 2008.
2. Yousry T, Habil M, Major E, et al. Evaluation of Patients Treated with Natalizumab for Progressive Multifocal Leukoencephalopathy. N Engl J Med 2006;354:924-933.
3. Rudick R, Stuart W, Calabresi P, et al. Natalizumab plus Interferon Beta-1a for Relapsing Multiple Sclerosis. N Engl J Med 2006;354:911-923.
4. Polman C, O'Connor P, Havrdova E, et al. A Randomized, Placebo-Controlled Trial of Natalizumab for Relapsing Multiple Sclerosis. N Engl J Med 2006;354:899-910.
5. American Gastroenterological Association Institute Technical Review on Corticosteroids, Immunomodulators, and Infliximab in Inflammatory Bowel Disease. Gastroenterology 2006; 130:940-987.
6. Lichtenstein GR, Hanauer SB et al. American College of Gastroenterology Practice Guidelines on the Management of Crohn's Disease in Adults. Am J Gastroenterol 2009; 1-19.
7. Hutchinson M, Kappos L, Calabresi PA, et al. The efficacy of natalizumab in patients with relapsing multiple sclerosis: subgroup analyses of AFFIRM and SENTINEL. J Neurol 2009;256:405-415
8. Coyle PK, Foley JF, Fox EJ, et al. Best practice recommendations for the selection and management of patients with multiple sclerosis receiving natalizumab therapy. Mult Scler 2009:15:S26
9. Kappos L, Bates D, Hartung H, et al. Natalizumab treatment for multiple sclerosis: recommendations for patient selection and monitoring. Lancet Neurol 2007;6:431-41.
10. Havrdova E, Galetta S, Hutchinson M, et al. Effect of natalizumab on clinical and radiological disease activity in multiple sclerosis: a retrospective analysis of the Natalizumab Safety and Efficacy in Relapsing-Remitting Multiple Sclerosis (AFFIRM) study. Lancet Neurol 2009;8:254-60.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
Initial Review	3/22
Updated initial authorization duration to 1 year	02/23

Record Retention

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

Disclaimer

CountyCare medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of CountyCare and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

CountyCare reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

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